Medicare Part D – Plan Selection Information

Name: _____ **Medicare #:** _____

Effective Date Hospital A: _____

Birth Date: _____ **Effective Date Medical B:** _____

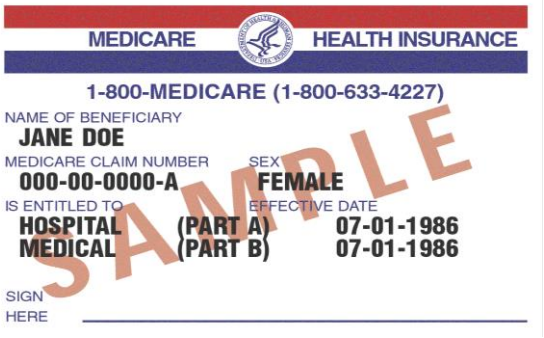
** The information above can be found on your Medicare card, example below

Address: _____

_____

Zip Code: _____

Phone: _____



Please write any Insurance you currently have (examples: SeniorCare, Supplemental Insurance, Medicare Advantage or Part D plan, Medicaid (Medical Assistance), Retiree/Employer coverage, etc.

_____

The state helps pay Medicare costs (Premiums, deductibles, and/or co-insurance)? ☐ Yes ☐ No

Pharmacy – 1st Choice: _____

If you are interested in exploring another Pharmacy for a Cost Comparison, please list:

_____

Drug Name	Strength (mg/ml)	Dosage(1/day or 30/mo)

Please put spouse's information on the back side of this form if applicable.
Feel free to attach a list of your medications provided by your pharmacist.

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